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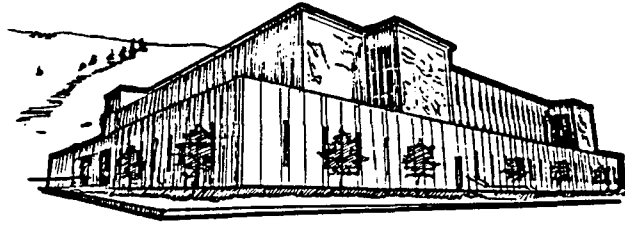
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University of  
**Montana**



**DEVELOPING A COMPREHENSIVE  
SUBSTANCE ABUSE PROGRAM ON THE  
FLATHEAD RESERVATION**

**By**

**Anna Whiting Sorrell**

**B. A., University of Montana, 1980**

**Presented in partial fulfillment of the requirements**

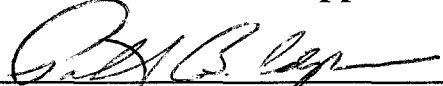
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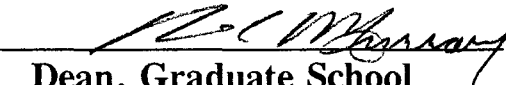
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**1993**

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# CHAPTER I

## INTRODUCTION

Substance abuse is one of the major health problems among the estimated 1.66 million Native Americans in the United States (Rhoades:622). Alcohol and other drug use is cited as directly contributing to four of the ten leading causes of death for this ethnic population. These causes include accidents, liver disease (cirrhosis), homicide, and suicide. Furthermore, alcohol and drug use is considered an indirect factor in the remaining causes which include heart disease, cerebrovascular disease, diabetes, cancer, and pneumonia. Finally, it is a known cause for the fatal conditions affecting newborns (Willer:1). Dr. Everett Rhoades, Assistant Surgeon General and Director of Indian Health Service stated, "It is clear that alcoholism and its secondary effects play a preponderant role in the overall mortality of American Indians." (Rhoades:621)

While a number of Native American people die each year as a result of substance abuse, many more experience the effects of it. Chronic disability, loss of earning capacity, family disruption, incarceration, and considerable pain and illness are just some of the most devastating effects associated with this disease. Data available in delinquency, homicide, assaults, and other criminal justice statistics further reflect the sociocultural impact of alcohol and other drug abuse. Fetal Alcohol Syndrome (FAS) is a problem in the Native American population "with untold consequences" (Willer:5). One study places the FAS rate among one tribal group as 40 per 1,000 births, which is approximately 100 times greater than the non-tribal rates.

The economic costs are just as staggering. In 1979, it was reported that

"approximately 70 percent of all treatment services provided by the Indian Health Service (IHS) directly through its hospitals and clinics, or purchased by the IHS from contract providers are for alcohol related conditions." (Andre:2)

Research conducted regarding Native American youth and substance abuse concludes "more Indian youth use virtually every type of drug with greater frequency than non-Indian youth" (Goplerud:1). One study characterized the alcohol and drug problem among Native American youth as "a growing crisis and a major national scandal." Bernard McColgan, at the Office for Substance Abuse Prevention, has summarized as follows: "the dimensions of the substance abuse epidemic and its associated societal costs [among Native American youth] are appalling" (Austin:4).

The problem of substance abuse on the Flathead Indian Reservation is similar to that described through national statistics and research findings. The State of Montana, Department of Institutions, Alcohol and Drug Abuse Division in the 1985 report to the Legislature found approximately 70 percent of all adult Indians (residing on Montana reservations) abused alcohol or other drugs. The Billings Area Office for Indian Health Service, which serves the Flathead Indian Reservation, has the highest mortality rate from alcoholism (Rhoades:622).

The youth of the Flathead Reservation are either at high risk to abuse or are currently abusing substances. In 1984, Britt Finlay compared students on the Flathead Reservation with other youth by survey using a similar instrument. In the study, Finlay found that 21 percent of the youth of the two schools on the Flathead Reservation met the criteria for drunkenness and negative consequences related to drinking as compared to 5.5 percent for the nation. She



concluded that the Arlee students were four times more likely than other students to experience alcohol misuse.

In the Spring of 1987, Western Behavioral Studies at Colorado State University in Ft. Collins, Colorado, with a grant from the National Institute of Alcoholism and Alcohol Abuse, surveyed 237 Flathead Reservation youth in grades 7-12 from six reservation school districts. The survey was limited to only those students in school on the day the survey was taken. It did not take into account those students absent or those that had dropped out. The results were compiled in two categories: those that had ever used the particular drug in question and those that had used the particular drug in question in the last month. The results were shocking. For example, 90 percent of the local Indian students reported "ever having used alcohol" as compared to the national non-Indian rate of 57 percent when a similar survey was conducted. The "marijuana ever used" rate was 54 percent for the local Indian youth as compared to 24 percent for the nation's non-Indian rate. The comparisons between the two groups for use in the last month were similar. For example, 51 percent of the local Indian population had used alcohol as compared to 32 percent on the nation's non-Indian youth (Drug:11).

The Confederated Salish and Kootenai Tribal alternative high school, Two Eagle River School, reported to the Bureau of Indian Affairs in 1988 that 47 percent of the 114 students were involved in the juvenile justice system for alcohol or other drug related offenses. The Tribal Mental Health Program reported 100 percent of its case load was directly or indirectly related to substance abuse, as well as the Tribal Social Services with all of its foster care cases. In 1991, a Confederated Salish and Kootenai Tribal attorney attributed all incarcerations in Lake County to alcohol or other drug use.

Over the years, many researchers have tried to determine the cause for the high rate of abuse among Native American people. Dr. Patricia Mail, in a bibliography published in 1980, identified over 450 studies supporting 60 different theories or possible explanations. She divided the studies into three categories. The first included those studies focused on the biological factors including genetics. The second group focused on the psychological factors such as personality defects or aberrations. The final, and by far the largest group of studies, examined the sociocultural elements. These studies include a long list of causes which include acculturation, recreation deprivation, early exposure, poverty, unemployment, or a lack of norms.

A summary of the literature provides eight basic sociocultural explanations for the high rate of abuse in Native peoples. A listing of these explanations follows:

1. A history of discriminatory government policies.
2. A loss of cultural identity because of enculturation.
3. The culture has few constraints against chemical use.
4. Unclear legal and social status of Indians.
5. A lack of awareness of rights of Native Americans.
6. The prevalence of educational and occupational failure.
7. Self-image distorted by stereotypic view of the "drunken Indian".
8. Prevalence of family problems and family disruption (Willer:10).

Although the literature documents the extent of Indian drinking and drug use and further provides possible causes, there is minimal research on recovery and possible programs to be

implemented to facilitate the recovery process. Yet, for those residing on reservations and being intimately involved with Native people daily, the abuse and dysfunction that addiction brings is overtly apparent. What is not apparent are the types of services required to impact this devastating problem and help to ensure healthy and happy lives for future generations.

The Confederated Salish and Kootenai Tribal Council recognized substance abuse as a major health issue with serious consequences in 1984 when it voted to revise the substance abuse services being provided on the Reservation. The Council recognized a complete revamping would be required due to the level of the problem and the ineffectiveness of the current program to impact it.

The purpose of this paper is to assess the need for community-based substance abuse services, including the complete continuum of care defined as prevention, intervention, treatment, and aftercare. This assessment will be done by examining the Confederated Salish and Kootenai substance abuse services originally known as the Alcohol Program and later renamed the Tribal Human Services Department of Alcohol and Substance Abuse Program (ASAP). It will focus on the need for a comprehensive program designed on a tribal-specific philosophy to guide it. It will provide recommendations for additional services to enhance the current services provided by ASAP and other Tribal programs in order to provide the highest quality of services for the residents of the Flathead Indian Reservation. Finally, suggestions will be offered on the possible impact for other social services programs.

## **CHAPTER II**

### **HISTORY OF TREATMENT SERVICES**

The history of substance abuse services for Indian people must begin with the Indian Health Service (IHS), for it is the agency designated by the United States Government to carry out its health care obligations to tribes. IHS is housed within the Public Health Service of the Department of Health and Human Services (HHS). It "has the responsibility for providing comprehensive health service to American Indian and Alaska Native people in order to elevate their health status to the highest possible level" (Trends:1). The IHS stated mission

"is to ensure the equity, availability, and accessibility of a comprehensive, high quality health care delivery system providing maximum involvement of American Indians and Alaska Natives in defining local areas and managing and controlling their health programs." (Trends:1)

This federal responsibility is based on laws passed pursuant to its authority to regulate commerce with the Indian nations explicitly specified in the U.S. Constitution (Article I, Section 3) and in other pertinent authorities which would include signed treaties between the United States Government and Indian Tribes. IHS also serves as an advocate for Indian people to ensure they have knowledge of and access to all the federal, state, and local health programs they are entitled to as American citizens. In carrying out these responsibilities, IHS has defined the health services delivery system to include prevention, curative, rehabilitative, and environmental services.

IHS was officially formed in 1954 through P.L. 83-568, the Transfer Act (Trends:1). In its early days, the agency focused on controlling acute and chronic infectious diseases. This type of disease was devastating Native populations and was amenable to traditional therapeutic practices familiar to the IHS medical staff. By 1969, as IHS began to see success in this area, it realized it must expand to other health areas.

The United States Congress recognized the impact alcohol abuse was having throughout the country, including Indian communities. In response, it passed the Comprehensive Alcohol Abuse Treatment, Prevention, Rehabilitation Act of 1970. The law authorized the establishment of treatment facilities for Indian people located both on reservations and in urban settings. The authority to fulfill the intent of the law was given to the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

NIAAA administered Indian alcohol treatment programs until 1978. Then it began to transfer its authority to IHS. By 1983, the transfer of all 158 alcohol programs was complete. Although IHS has oversight authority for the alcoholism programs, the actual development and design, implementation, and evaluation rests in the individual tribes and urban organizations that enter into contracts from IHS. This contracting mechanism is available to the Tribes through P.L. 93-638, the Indian Self Determination Act of 1975 (as amended) which gives Tribes the option of staffing and managing IHS programs in their communities (Trends:1). At the point of transfer, the Tribes were given the primary responsibility to determine the program's direction, with IHS providing technical assistance and contractual oversight. IHS defined its role as: (a) defining the scope of alcohol treatment and prevention at all levels; (b) improving the

quality of care provided to persons in alcohol treatment programs; and (c) seeking ways to expand services available to Indian people (Rhoades:622).

The Confederated Salish and Kootenai Tribes began to provide alcohol treatment services in 1970 with a grant from the Office of Economic Opportunity (OEO). The program was named the Flathead Reservation Area Comprehensive Alcoholism Program (FRACAP). The funding for the FRACAP was assumed by NIAAA in 1972, and it was expanded to include additional services. The Flathead Service Unit, which is the administrative unit of IHS located on the reservation in St. Ignatius, MT, became active in providing alcohol related services as well in 1972 as it established a detoxification unit in a local hospital.

By 1975, under contractual agreements with NIAAA and IHS, the Tribe consolidated the services and moved from the medical setting to a non-medical unit with the construction of a 15 bed facility. Through the next nine years, FRACAP provided many services in varying degrees within the standard continuum of care for alcohol treatment services. At some point during the nine years, these services included medical detoxification, social detoxification, outreach, a halfway house, court liaison with a DWI court school, prevention, intervention, group counseling, family counseling, inpatient treatment, follow-up, and even a cultural component with funding from the Tribe. By 1984, the services of FRACAP focused on social detoxification and limited inpatient treatment with a decreased focus on outpatient counseling, outreach, and follow-up. A satellite office was opened in Polson, MT, at the request of the Lake County Commissioners with funding earmarked from alcohol tax money in the State of Montana. An additional contract was entered into between the Tribes and the State to provide a component for "hard-core" drug abusers.

When the Tribal Council reviewed FRACAP in 1984, it found that 12 repeating clients were utilizing approximately 60 percent of the available resources. "Detox", as it was more popularly known back then, provided nothing more than the basics, as described by the old army saying, "three hots and a cot." That is, clients received three meals a day and shelter with little or no alcohol or drug education or counseling. They voted to revamp the services.

As the new program developed, one asset remained in place -- the funding level. Even though the FRACAP experienced numerous changes in the program director position (seven between 1972 and 1984) and numerous program changes, the financial accountability was maintained, as well as the funding level. The result was that in 1984, the Alcohol Program was the highest funded P.L. 93-638 contract in the nation. Even though the Lake County Commissioners withdrew their support and the "earmarked" tax funds, the State of Montana maintained the contractual agreement with the tribes for the drug specific counseling services.

On a national level, IHS was also taking a hard look at the quality of services being provided Indian people. In 1985, it convened a group of individuals with a variety of skills and expertise to re-examine the current alcoholism treatment services. The group included IHS employees, federal employees, tribal leaders, and tribal alcoholism program directors and employees. The group was charged with the responsibility of reviewing existing programs and to make recommendations regarding the future direction for IHS. The Alcoholism Program Review was held in Denver, Colorado, in April, 1985. The review group made 173 recommendations which were synthesized into a manageable action plan for IHS. It became the guide to focus IHS activities in future years. The major theme of the review was that future efforts should be prevention oriented, especially prevention targeted at youth (Rhoades: 623).

An analysis of the shortcomings of the treatment services provided prior to the mid-1980s was best provided by Dr. Philip A. May from the University of New Mexico in Albuquerque. May identified nine problems common to many Indian alcoholism programs:

1. Inadequate funding;
2. Extremely poor pay and no career ladder for counselors and other employees;
3. Counselors with little or no professional training;
4. Counseling generally limited to individual, adult clients with little emphasis on family and community;
5. Isolation from professional and community input;
6. Neglect of the Indian spiritual aspects of life;
7. Little follow-up;
8. A need for diversified staff and treatments; and
9. No guiding theoretical or ideological perspective.

He concluded that "Indian alcoholism treatment can and must be improved in the future" (May 1986: 190).

May's findings were collaborated by a study contracted by IHS in 1984 (Raymond:1). It reviewed 12 "model" or successful Indian alcoholism programs from throughout the country. The authors stated the need for increased funding, career development, new diagnostic instruments, and improved follow-up procedures. Finally, it called for new models for prevention and outreach.

Recent research on the topic of Native American alcoholism and drug addiction has reaffirmed these findings with recommendations for community-based programs with a specific



component focusing on prevention. Dr. Steven Schinke recommended a "close and ongoing community collaboration" (Schinke: 65). Furthermore, Schinke determined the collaborative effort must begin early in the planning process with lay persons and professionals as equal partners. He added that the programs must be developed in a positive light, focusing on the strengths of the Tribe and community.

Fred Beauvais supported Schinke when he called for "new intervention congruent with the current move toward self-determination in Indian Country" (Beauvais: 169). He further recommended against "externally imposed solutions." Success, he wrote, would best be achieved "if the spirit of the community could be bolstered and hope delivered through communal action and mutual support" (Beauvais:169).

Research also supports the need for increased awareness of the addiction and its overall impact and effects in reservation communities. It is believed, through the education process, communities would be empowered to change the accepted norm of drunkenness or other prevalent attitudes held in Indian country that contribute to the alcohol and other drug problem. Dr. Dwight Heath recommends the lessons be provided to the entire community and focus on changing the "unhealthy attitudes". He targeted the following attitudes as prevalent and requiring modification:

1. A general attitude that alcohol abuse is the acceptable way of drinking;
2. That drinking is the primary recreational activity in many Indian communities;
3. That problems that arise from drunkenness are excused or taken for granted "because the person was drunk" (Heath:218).

Heath further recommended the education model utilized to change attitudes not be conducted in a classroom situation but be "tailored to the language, meanings, understandings, values, and general cultural ambience of a particular community" (Heath: 218).

As programs are developed to prevent this problem, the literature summarizes essential components if programs are to be successful for Native Americans. The programs need to target Indian youth before they begin to use or abuse. They must include social activities and alternatives to use, so youth involved feel accepted within a peer group or community. The program must enhance self-image and cultural identity. The programs developed need to involve family members. Another possible component, determined effective in other areas, is peers teaching peers. The programs should include an educational component to identify the effects of chemical abuse, early signs of chemical dependency, and provide information on fetal alcohol syndrome and effects (Willer: 11).

Few could debate the overwhelming need for substance abuse prevention or quality treatment for Native Americans. The need was apparent to the Confederated Salish and Kootenai Tribes. It was a challenge they were willing to undertake.

# **CHAPTER III**

## **SUBSTANCE ABUSE SERVICES ON THE FLATHEAD RESERVATION**

The Confederated Salish and Kootenai Tribal Health Department Alcohol Program knew the problem of substance abuse existed in a tremendous magnitude as it began its reorganization in 1984. The staff recognized the widespread effects of chemical abuse, not only in individuals, but in families and the community. Since no program recovery model existed, the program moved forward by developing a philosophy as a guide.

The philosophy was based on four guiding principles taught and lived by the tribal elders. These simple principles were neglected in the Native people's attempt to fit into the mainstream. Mr. Phil Lane, Jr., from the Four World's Development Corporation located at the University of Lethbridge, British Columbia, Canada, conducted a series of workshops on the Flathead Reservation between 1984 and 1988 which helped remind the Program and its staff of the appropriateness and applicability of these principles to program design and development. Close examination of the principles helped open the staff's eyes to the teachings, common sense, and wisdom of the local elders.

The principles are as follows:

1. "The heart of the problem lies in the community and the solution must come from the same." The Indian people of the Flathead Reservation inherently know how to overcome the problem of substance abuse, if empowered to do so. The culture, values, and beliefs hold the answer. Outside programs and experts can assist; but ultimately it must come from those who are experiencing the trauma to determine the solutions.

2. "Learning is a continual process." Human beings learn from the time of birth until death. The lessons come from a variety of sources. In life, only about ten percent of learning comes from the formal education process through the school system. The remaining 90 percent comes from life experiences. The lessons are taught by parents, grandparents, brothers and sisters, or children. The lessons occur in a variety of environment such as homes, churches, playgrounds, or "in the street." The learning tools include books, games, television, music, or simple daily interaction between people.

Learning is an essential part of the growth process. It is an essential element in changing behavior, especially when change is the result of past mistakes. Without learning, people stagnate and die.

3. The future is tied to our past. It is impossible to move to the future without knowing the past. This is particularly true with American Indians. Indian people have a rich history based on a strong sense of community and communal values and beliefs. It was a way of life that promoted a healthy life style based on interconnectedness. It did not promote individualism nor independence, but a sense of belonging and the common good among all people. This way of life was stripped away from Native people through hundreds of years of broken promises and treaties. It was destroyed by the dependency encouraged on reservations and fostered by the welfare system of food stamps, commodities, low income housing, and government owned hospitals and schools. For many individuals, the only way to survive the losses was to medicate the pain with alcohol or other drugs.

Although the drinking and drug taking can be looked at as the way past generations medicated their pain, the intense internal pain related to the many losses suffered such as loss of culture, loss of religion, or loss of language, it can also be looked at as a means of rebellion or defense against the oppression occurring. It still must be examined with special consideration given to the multi-generational effects that it had on families, communities, and the Tribe as a whole. In August, 1989, Mr. Ken Ryan, a spiritual leader from the Ft. Peck Tribes in Montana, said, "Indian people are not only the children of alcoholics. We are the grandchildren and great grandchildren" of individuals who have suffered from addiction.

The Alcohol Program of the Tribe needed to look not only at the positive aspects of the "past," the strength in our ceremonies and rituals, the strength of Indian families and values, and the resiliency shown by our past generations as Tribes survived into the 1990s. The Program needed to acknowledge the negative aspects of the past and ensure conscious decisions were made to not bring the results of the decisions into the future. It must be noted that this was not to blame or shame the elders or others that made decisions resulting in addiction as it was understood that the decisions made were "the best available at the time,"

but different decisions could be and needed to be made in the future to interrupt the generation effect of chemical dependency.

4. "The pain of one is the pain of all." This principle is the simplest and yet the most difficult to understand. It is the one most commonly recognized as a universal tribal value. It is founded on the belief of the common interest for the good of the tribe.

To understand the fourth principle and its relevance to the Alcohol Program, there must be an understanding of one of the past common approaches related to chemical dependency. This approach was to blame the victim and consider the victim as weak or immoral. This approach excluded the impacts that alcohol and drug use had on the family, community, and Tribe and worked to degrade the individuals with the disease. Recovery was extremely difficult under this approach.

The Alcohol Program used this fourth principle to develop another approach. This approach was designed to engage the entire reservation community into a healing process. Each individual on the reservation had either directly or indirectly been impacted by addiction, and each person deserved to recover. The recovery model was based on the acknowledgement and healing of the pain by sharing it with each other.

Alcoholism is a progressive disease with distinct patterns and symptoms experienced by those inflicted with the disease and those indirectly associated with its outcomes. This is one of the reasons the American Medical Association defined it as a disease in the 1950s. This is probably the reason Alcoholics Anonymous (AA) has worked so well. Once it can be acknowledged that the individuals have similar experiences and share similar pain, the recovery is possible. Until individuals are made aware of the positive possibilities in community recovery, they will choose pain over being alone. The Alcohol Program took the fourth principle and challenged the Tribe to collectively acknowledge the pain, share the individual pain with each other, heal it, and move forward to impact other people's lives. The principle of the "pain of one is the pain of all" becomes a starting point to encourage individuals to move in a healthy direction of despair to hope, from sadness to happiness, and finally from pain to joy, which will ultimately turn the fourth principle into a more positive sharing of "the joy of one is the joy of all."

Using these as the guiding principles, the Alcohol Program of the Confederated Salish and Kootenai Tribes proceeded to develop its program components, which at that time were reservation-wide prevention, community-based counseling, and a multi-disciplinary staffing team.

In its early development, the Alcohol Program designed its components based on the standard continuum of care of alcohol services. The continuum was defined by the Alcohol Program as prevention, medical detoxification, in-patient treatment, out-patient treatment, and aftercare. The offices and staff moved into five of the largest reservation communities, and procedures were defined to access all components on the continuum. Quality treatment remains the primary objective of the community-based counseling component. A reservation-wide prevention program was designed primarily on the utilization of Alcohol Program owned Here's Looking At You, 2000 school-based curriculum kits developed in King County, WA.

A multi-disciplinary team was formed which included a medical doctor, a clinical psychologist, a medical social worker, mental health professionals, and chemical dependency counselors. The team was charged with the responsibility of developing individualized treatment plans and ensuring quality services, since quality care was the most essential aspect of developing credibility in the communities. The team also offered an opportunity to network with other social service providers (i.e., court, school, juvenile probation, foster care social workers, child protection services, and churches) by providing a forum to assist in treatment planning on their cases.

The Program operated in this fashion for approximately three years. As the staff reviewed the outcomes, it was apparent something was missing. The standard continuum of care was not working. This was not so surprising as the Program was caught in a "Catch-22". A recovering individual needs to return to a supportive community; yet for the community to be supportive, there needs to be a break in the hopelessness and helplessness associated with living with the disease. The community needed to see successes. To prevent youth from repeating negative survival patterns by medicating their pain with alcohol and drugs as the generations before, the youth needed to have adults modeling healthy behaviors and skills. It was apparent that a new component within the continuum of care was needed -- something new and unique.

At the time the Program realized this need in 1989, the Office for Substance Abuse Prevention (OSAP) was requesting proposals to award demonstration grants within a category entitled, "Comprehensive Prevention, Treatment and Rehabilitation Demonstration Projects for High Risk Youth." The Tribes submitted, "A Comprehensive Proposal for the Blue Bay Healing Center." It was funded for the requested three years beginning in September, 1987, and was

completed in August of 1990. The proposal contained three primary goals as described by a multi-colored graphic design. The graphic design is included in Appendix A. It reflects the multiple service levels developed to achieve the goals developing a culturally relevant healing process that would engage the entire reservation population and a training component specific to the needs of the Blue Bay Healing Center Project. The trainings were provided to three groups with impact on reservation youth. The groups were:

1. Alcohol Program Staff/Multi-Disciplinary Team. A core of individuals were trained to provide quality services for high risk youth. It also recognized the fact that most staff had experienced the pain associated with the disease and needed an opportunity to examine their own recovery journey and continue their growth. If the staff continue with their own efforts, they would not be able to assist the clients at the Healing Center.
2. Human Service Providers. Training occurred for this group of professionals, as they have a tremendous impact on high risk youth. It was apparent the providers' policies and procedures often contributed to continued use as opposed to recovery. This was based on lack of awareness about chemical dependency. This group also needed to look at personal issues related to chemical dependency and how their personal attitudes impacted the work performance.
3. Community Members. Training occurred for this group to develop a network of healthy adult role models for high risk youth. This group also lacked basic education on the issues in chemical dependency and personal understanding of the efforts, either directly or indirectly on their lives.

To fulfill these goals, services provided at the Blue Bay Healing Center were categorized into the following five goals:

1. In-Residence Component. This component provided an intensive retreat at varying length for individuals and families in recovery. Age appropriate services were provided to children, adolescents, and adults, in separate tracks with a coming together for particular activities and group sharing. A variety of issues were presented and discussed.
2. Training for High Risk Youth. This component provided intensive training for adolescents on a variety of topics which included inhalant abuse, basic alcoholism and drug addiction education, living in foster care, and children of alcoholics.
3. Training for Service Providers. This component provided training to reservation service providers on similar topics as the high risk youth, but allowed for an

opportunity to explore how their attitudes toward alcoholism affected their job performance and provision of services.

4. Healing of the Care Giver. This component provided opportunities for staff to process their issues, which often times were identified in the intensive work with the clients. In a community-based model, the services are provided by community members, family members, and tribal members.
5. Community Activities. This component provided a wide range of activities for those individuals choosing to "CELEBRATE LIFE . . . DRUG FREE." The activities were open to all community members with special attention given to Blue Bay Healing Center "Alumni". All activities were available for family involvement. The activities included pow wows, stick game tournaments, song festivals, campouts, dances, and many many more. Youth and adults were able to experience having fun in sobriety.

The impact of the incorporation of the Blue Bay Healing process into the continuum of care provided by the Alcohol Program has been overwhelming. Many tribal people believe it will ultimately be an essential element in the prevention and elimination of the devastating effects of substance abuse. Program staff are repeatedly encouraged when they hear the support and belief in the Blue Bay Healing Center. It is also viewed as a national model.

By 1988, the Alcohol Program's reorganization had been in operation approximately three and a half years. It was a natural time to evaluate the effectiveness of its services. The task was undertaken on a variety of levels. The first was designed to evaluate the overall effectiveness of the entire Alcohol Program. Second, since the Blue Bay Healing Center was such a new and innovative project, it was decided that special evaluation attention should be focused on it. Also, extensive evaluation was required by OSAP as part of its high risk youth demonstration grant program. Two separate evaluations of the Blue Bay Healing Center were conducted.



The overall Alcohol Program's evaluation was conducted by Evaluation Research Associates in Missoula, MT, by Drs. James A. Walsh and Dudley A. Dana. The evaluation had two primary goals. The first was to "generate baseline data with which to assess and document the progress of the Alcohol Program over the last four years" and, second, "to provide, through the assessment, a rational basis for planning the intermediate and long-term development of the program" (Walsh 1988:4). The overall conclusion of the evaluation was

"the Alcohol Program is well known and well regarded on the Flathead Reservation. Given the limitations of its resources and the fact that it serves a population that is in many respects greatly afflicted and underprivileged, the Alcohol Program provides effective treatment to its clients and an influential program of education and prevention to the residents of the Reservation" (Walsh 1988:81).

Some of the specific recommendations made were to improve ex-client follow-up, include additional recreational and social activities (especially at a community and neighborhood level), consider including an employment counseling unit, and improve the family program. In terms of the quality of treatment issue, it was recommended that counselors increase the number of client contact hours, improve screening procedures, and improve the referral network with which clients were generated for the Program.

The two evaluations of the Blue Bay Healing Center component were conducted by the Evaluation, Management, and Training Associates (EMT Associates) from Sacramento, CA, and the other was part of the national evaluation process contracted by OSAP to MACRO Systems, Inc., from Silver Springs, MD. The evaluators from the national evaluation were Drs. Marge and Dan Edwards from the University of Utah in Salt Lake City, UT. The outcome of both evaluations was similar. Both supported the approach and implementation of services provided

by the Blue Bay Healing Center. Both agreed on the capability and commitments displayed by the Center's staff. Both were impressed with the facility and commented on the beautiful location and its positive impact on "healing". Both viewed the Tribe and the Program's administration as capable of effectively overseeing the grant and ensuring its completion of stated goals and objectives. In addition, the format of the MACRO evaluation required tribal service providers and individuals receiving services from Blue Bay to be interviewed. The evaluators commented on the widespread awareness of the Program held by local people.

The Blue Bay Healing Center Project was able to increase the awareness of the general Indian population regarding this disease. Through the healing process, Blue Bay participants have identified where they are and how they got there, and they have made a commitment to move in a new direction. They began to accept responsibility for their own behavior and, more importantly, how their behavior impacted their children and other Indian children. Yet, making the actual change was extremely difficult when individuals returned to their extended families and communities (which were often not supportive of the change). Change in behavior can be slow. It is usually made in small increments. Often times, there is "relapse" or a returning to the old behavior. Yet, with encouragement and support, the ability for individuals, families, and communities to change behavior can occur.

Although both evaluations were extremely supportive, one common recommendation was made. It was the need for follow-up activities in the local reservation communities. The wide range of services provided through the Blue Bay Healing Center Project had a tremendous impact on the individuals and families that participated. Yet, in order for the increased awareness and the decision to make a behavioral change be long-term, there had to be continued

community and family support and local opportunities to interact with others who have made a similar alcohol and drug free choice.

In response to the evaluations, the Alcohol Program began to re-examine the services it offered. The changes also occurred because the OSAP Blue Bay Healing Center grant was concluding. IHS was also requiring a re-examination of the services provided under the P.L. 93-638 contract due to its increased funding level from monies received through P.L. 99-570, the Anti-Drug Abuse Act of 1986. In the Congressional Record of October 17, 1986, it was stated that "nothing is more costly to Indian people than the consequences of alcohol and substance abuse." Congress mandated IHS and the Bureau of Indian Affairs (BIA) cooperatively to develop a new prevention initiative and enhance the current efforts in treatment and rehabilitation services.

The major focus was to determine the "next step" in community-based program process. As staff discussed this issue and the evaluations, it was clear that the services provided at Blue Bay needed to continue and, in fact, be available in each of the local communities. In terms of treatment, additional services were required to increase availability and specific services for alcohol and drug abusing adolescents.

The graphic design used by the Blue Bay Healing Center was revised to include all of the services provided by the Alcohol and Substance Abuse Program. ASAP was the new name given to the Alcohol Program to reflect the organization changes occurring within it. ASAP acknowledged the services provided to those individuals affected by all drugs, including alcohol. Furthermore, it acknowledged the need for action "as soon as possible." It was during this time that ASAP was moved to the newly created Tribal Human Services Department with the Tribe's

Mental Health Program and Tribal Social Services Program. The move was based on the premise that quality services would be enhanced if these three programs were in one department due to the similar clients utilizing the services and similar case management and administrative needs. In addition, social service programs are looking at a community response to child abuse and neglect. The lessons learned by the Alcohol Program could be used as the Tribal Social Services Program undertook this type of programming.

The revised graphic design illustrated ASAP's continuum of care in a cyclical fashion as opposed to the traditional linear fashion. It divided the circle into four segments: a segment for prevention, intervention, treatment, and aftercare. It describes program planning and implementation needed in each of these areas which must include appropriate services for all age groups including children, youth, adults, and elders. Furthermore, services were needed for all segments of the population in terms of the individual, family (both personal and professional), community, and the Tribes.

Finally, the approach to be used is based on ASAP's guiding principles and utilizing the specific approach defined in a theory which explains how "change" in behavior occurs. It was developed by Mr. Bob Marsenich, the co-founder of Metamorphosis, a consulting and counseling firm in Missoula, MT. His theory is called, "The Steps of Change." It includes four steps which build on one another in a series. The four steps are as follows:

- **STEP I -- AWARENESS.** This first step is the acknowledgment that there is a problem. It is the "ah-ha" experience or in a cartoon when the light bulb goes off over the character's head. This is the step where there is a definition of the problem. There will not be a change in behavior until it is realized as a problem. Also, the awareness must include motivation to do something about it.
- **STEP II -- UNDERSTANDING.** Mr. Marsenich is quoted, "understanding comes from discovering both past establishments and present manifestations of the

behavioral patterns that need to change" (1983). It is at this step where the person examines where they have been, where they are at, how they got there, and finally where they want to end up. Here an individual integrates new knowledge with old, with a focus on the benefits of changing. This is also the stage for data collection.

- **STEP III -- ACCEPTANCE.** In the third step, the individual or community accepts responsibility for his or her behavior. It should be noted that taking responsibility does not have to be a repressive burden or a source of guilt or placing blame. Responsibility is the ability to respond to ourselves, our families, our community, and our Tribe. In acceptance, individuals learn they have the power to change their behaviors or situations. They are not required to react in the old pattern. One of the beliefs in this theory is that "positive intention lies behind most human behavior" (1983, p. 63). This applies in a community-wide prevention model when the concept of professional enabling is examined. Some service providers and family members shelter chemical abusers from the consequences of their action because they do not want the abuser to hurt anymore than they already do. They do it to protect them. Yet, their action allows the disease to continue. Thus, the negative behavior (enabling) has a positive intention. In acceptance, there must also be an emotional commitment to impact the situation by using the ability to respond and move in the desired direction toward a change.
- **STEP IV -- CHANGE.** Once an individual accepts they have the ability to respond in a situation they will move to the final step -- change. Change consists of identifying alternatives; continuing to do the new behavior; and rewarding yourself for practice, repetition, and small wins which lead to success. Through time and experience, the new behaviors will be integrated into the individual's repertoire of responses. In any change, there is a risk involved. There is a natural tendency to stay with the status quo. Fear of the unknown can cause a person to stay with a negative behavior. It is through encouragement and support, often by community members, that individuals can accept the challenge to move in the new direction (Marsenich, 1989).

The "Steps of Change" theory is applicable to a community-wide program model in that it lays a foundation for realistic expectations toward goal and objective accomplishment. It is simple and can be comprehended throughout the community. Much of what is intended to be accomplished by ASAP is change in behaviors, behaviors that have been practiced for many,

many years. ASAP began a major transition in the program's operation as services were either revised and additional services were created to fulfill voids as identified in the graphic design and through the evaluation.

The first major development of this continuing transition occurred when ASAP was awarded a second high risk youth demonstration grant from the Office for Substance Abuse Prevention (OSAP) entitled, "Beyond Blue Bay". The grant allows ASAP to move the concepts developed through the Blue Bay Healing Center to the nine major reservation communities over the five year grant award.

There are four goals of the project:

- The first is to develop community action prevention teams (CAPT) in each of the nine communities. The CAPTs are responsible for developing ongoing alternative activities for youth. In order to accomplish this goal, the team members make a commitment to be role models and gain awareness of addiction and its impact in the family, community, and the Tribe.
- The second goal is to develop a cooperative network between the CAPTs to share information and gain support from each other.
- The third goal impacts the entire reservation through the implementation of reservation-wide events and trainings aimed at changing the prevalent attitudes regarding chemical dependency.
- Finally, the fourth goal allows for intensive training, retreats, and treatment which will be conducted at the Blue Bay Healing Center and enhance the first three goals.

Implementation of the Beyond Blue Bay grant began in November 1990, when the staff was hired and orientation began. The first three communities to be worked with over the first two years of the grant were chosen by the Tribal council. They were Elmo, Arlee, and Ronan.

The remaining six communities, Polson, Pablo, St. Ignatius, Hot Springs, Charlo, and Dixon would be added in intervals of years three and four of the grant.

The Beyond Blue Bay grant permitted ASAP to include two additional components into a continuum of care of services. A full-time recreational coordinator was hired to assist the CAPT with appropriate recreational activities. This position allowed ASAP's Summer Outdoor Recreational Nature After Program (SORNAP) to be expanded to include year round activities. This change was viewed as essential since recent research from OSAP demonstrates the need for ongoing, consistent prevention programming as opposed to limited events.

The cultural coordinator was the second addition to ASAP's overall program. This position was drastically changed from the cultural specialist position funded in the Blue Bay Healing Center grant as it now would assume responsibility to ensure all activities provided by ASAP would be implemented in a manner that was consistent with Salish and/or Kootenai culture. The change in the position forces ASAP to look at its operation and include, modify, change, and exclude portions which do not enhance the tribal culture. It no longer allows ASAP to be a "culturally relevant" program because it is located on an Indian reservation and staffed by Native Americans. It forces ASAP to take an active role in developing its program to enhance the cultural competence of its participants.

The Beyond Blue Bay Project is supported by the development of an ASAP Prevention Team. The team includes Blue Bay staff plus four positions funded through the IHS contract. Together, the team provides a wide range of activities focused on prevention and also aftercare. This is based on the belief that those activities which prevent individuals from using alcohol or other drugs are the same as those that keep individuals from relapsing to old behavior of

drinking and taking drugs. This level distinguishes ASAP's continuum of care as unique from other programs. In most other programs, the continuum of care is linear with detoxification at one end and aftercare at the other end. ASAP's continuum of care is cyclical, with the prevention and aftercare coming together to complete the circle as the graphic design illustrates. The CAPTs add an additional dimension to the circle as it is changed with the responsibility of moving the circle, giving it motion and life. Since the prevention, intervention, treatment, and aftercare services are provided by one program, this program helps reduce the traditional split between prevention providers and treatment providers.

The success of the services provided by Blue Bay Healing Center could not be abandoned once the first grant concluded. To ensure the services it provided continued, two components were instituted. The first was already mentioned in the Beyond Blue Bay Project. The second was through the IHS contract with the inclusion of a primary planner. This planner is responsible to plan events, retreats, and trainings similar to those originally provided at the Healing Center. The targeted population is the entire reservation population, with a special focus on Tribal employees. It is through this component that ASAP has been able to train over 140 employees in an intensive four day workshop entitled, "Chemical Dependency Awareness and the Drug Free Workplace Act of 1988." Attendance at this training has been mandated by the Tribal Executive Secretary for all Tribal department heads, program managers, and supervisors. The primary planner is responsible for overseeing ASAP retreats conducted at the Healing Center or day-long workshop throughout the reservation with a variety of target audiences.



Another ASAP addition since the 1988 evaluations is the Adolescent Inpatient Treatment Component. In 1988, ASAP closely examined the IHS funds being expended for sending reservation youth to inpatient treatment facilities located off the reservation. It was found that there was no success, with success defined as the adolescent maintaining any sobriety once the treatment was completed. Thus, the Tribes pursued a P.L. 93-638 contract to provide inpatient treatment services locally with a tribal specific treatment modality. After a lengthy negotiation process, IHS entered into a contractual agreement with the Tribes to provide adolescent inpatient treatment for 20 IHS eligible youth in fiscal year 1989 and additional youth each year thereafter.

In order to enhance the quality of services provided on the Reservation, the Tribal Council directed ASAP to develop a certification process for chemical dependency counselors. The process was to be equivalent to or exceed the certifying standards of other certification processes available by the State of Montana or throughout the nation. The process was developed and implementation began in 1991. When the State of Montana began to require counselors to have an associate of arts degree in chemical dependency or a bachelor of arts degree in a human services related field, ASAP worked with the Salish & Kootenai College to become the third college in the State to offer an appropriate AA degree.

Two treatment components have been added. The first is an intensive outpatient component (IOP). The second is a family education component. Both components were funded at the end of fiscal year 1991, with staff positions filled at the end of the calendar year 1991.

Additional prevention services were instituted in September 1991. SOARING EAGLES is a primary prevention program for youth between the ages of 8 to 18 choosing a drug free lifestyle. The groups meet twice a month with the two meetings focused on one of the areas

identified in the UNITY-2000 - National Indian Youth agenda. The UNITY-2000 model identifies twelve components as follows:

- |                 |                |
|-----------------|----------------|
| 1. Health       | 7. Environment |
| 2. Economy      | 8. Heritage    |
| 3. Sobriety     | 9. Sovereignty |
| 4. Service      | 10. Family     |
| 5. Spirituality | 11. Individual |
| 6. Unity        | 12. Education  |

A "professional CAPT" (PRO-CAPT) was formed in November 1991, with the purpose of developing a cooperative network for programs working on the Reservation. The PRO-CAPT consists of representatives from Tribal Health, Juvenile Probation, Tribal Court system, YMCA, Family Crisis Center, and Social Services. In addition, Tribal departments which are not necessarily seen as specialty providing services to youth but can be brought into the delivery system are included (e.g., Tribal Natural Resources Department, Fish and Game, Bureau of Indian Affairs, and Indian Health Services). The "PRO-CAPT" team is working to raise awareness in services providers' issues in working with youth, identifying resources, and then actually coordinating services to promote wellness which in turn will reduce the alcohol and drug use among Salish and Kootenai Native youth.

The year 1991 marked the passage of three years since the evaluations conducted in 1988. ASAP again underwent an evaluation process. Evaluation Research Associates with Drs. Walsh and Dana were again contracted to conduct an overall program evaluation. The stated purpose of the evaluation was the same as the 1988 evaluation with the 1991 report specifically intended to follow up that report. The overall findings of the evaluation were as follows:

ASAP is as well known and well regarded today as it was in 1988. In the three years just past, it has grown by more than 50 percent in terms of personnel and has greatly expanded its programmatic emphasis on education/ prevention. Although ASAP is exhibiting the kind of organizational growing pains to be expected in any rapidly expanding operation, it appears to provide a more effective treatment program than it did in 1988; and it gives promise of developing one of the first truly effective community level prevention efforts through its Community Action Prevention Teams -- CAPTS" (Walsh 1991:85).

Another evaluation was conducted by EMT Associates, Inc., the same firm contracted to conduct the Blue Bay Healing Center project evaluation. At the end of the first full year of operation, the evaluation "emphasized description and analysis of program concept and rationale of the Beyond Blue Bay program design and implementation" (Phillip 1992:59). The first year report concluded with the following:

The Beyond Blue Bay program is established in three communities and offers an exciting approach to working with high-risk youth and communities. This report has documented areas in which further program development is appropriate. The continued maturation and improvement of the Beyond Blue Bay program in the coming years has the potential to make a strong contribution to prevention on the Flathead Reservation" (Phillips 1992:59).

ASAP plans to continue current operation while looking for additional resources to fill gaps in the services delivery system. The identified gaps include adult inpatient treatment, rehabilitative services for clients involved in the Tribal justice system for alcohol or drug related offenses, specific services for women, particularly pregnant women and women in childbearing years at risk for producing fetal alcohol syndrome affected children, employee and student assistant programs, and age appropriate intervention and treatment services for college age young adults, and elders.

The Tribes continue to support the approach begun in 1984 through the Alcohol Program, then ASAP. Through the years of development, its advantages far outweigh the disadvantages. For example, the Tribes' approach to providing substance abuse services on the Flathead Reservation is different from that in other programs because one program oversees the entire continuum of care. Generally, one program or agency or school district is responsible for the prevention component. Another program is responsible for outreach and outpatient treatment. Finally, another program provides the inpatient treatment. The element of community education and family education and treatment is divided among the three, with little or no communication or networking.

Since the Tribal Council oversees all Tribal operations, it has ensured that all substance abuse related services on the reservation are coordinated with ASAP. This coordination includes school programs, health services, and law enforcement services. Another benefit to a single administration is that a single philosophy guides the program component providing consistent services and a clear set of expectations to the clients. Finally, coordination helps eliminate duplication of services and administrative support services.

Since 1984, ASAP has been actively "pioneering" a Tribal Healing modality. The modality allows for services to be provided in a culturally sensitive manner and leads to cultural competence. The cultural competence reinforced or taught is not "generic" Indian, but rather specific to Salish and Kootenai people. The Tribal healing approach builds on the strength of Tribes as opposed to the risk or negative socio-economic factors that have resulted from generations of dependence on the Federal government. These strengths can be summarized as resiliency.

The Tribal Healing modality builds on five inherent resiliency factors. The first resiliency factor is that of belonging to something beyond self. Tribal youth "belong" to the Tribe, as well as to families and communities. Yet, Tribal youth do not always understand the meaning of such membership. In fact, often times it may be viewed in a negative manner if the stereotypical view of the "drinking Indian" is held. ASAP's cultural component is charged with the awesome responsibility of changing this view through education and skill acquisition.

The second resiliency factor is the belief held within the Tribes that children are a gift from the Creator. They are special by virtue of their existence, not who they are or what they have. The birth of a child is a celebrated occasion with Tribal communities. Children are viewed as the Tribe's greatest resource.

Another resiliency factor viewed as a protection within children is having other caring adults in their lives in addition to their parents. The extended family, with grandmothers and grandfathers, aunts and uncles, are still an integral part of Native communities. It is not uncommon for Indian children to be able to trace family roots back five or six generations and to have consistent and meaningful contact with many family generations.

The family rituals that are practical, consistent, and not disturbed by alcohol or other drugs are viewed as a fourth resiliency factor. The Tribes have a rich history of rituals which continue to be practiced today and which youth have access to if they choose. Rituals do not have to be created, but can be learned from those within the Tribe that have maintained the cultural integrity of the tribal system. This could be elders who are viewed as wisdom keepers or informal leaders that have achieved this special status within the Tribe.

The final identified resiliency factor is to have a sense of community. Looking back, the Tribes were a model for community living. Each person within the Tribe had a role or responsibility. No one role was viewed as better or worse, good or bad, but all were necessary for survival. It is a system which is relevant today. Each person needs to be validated as being a contributing member to society regardless of the special skill they bring. Community is about interdependence, not being dependent or independent. It is a value being held by Indian people and practiced daily.

The Tribal Healing modality looks to the wisdom of the elders for guidance and approval, unlike non-tribal programs that look to peers or governmental agencies. The elders serve as advisors in an informal capacity to guide the program. For example: The Tribal Healing modality utilizes elders to tell stories in the winter time to teach appropriate lessons to youth.

Addiction impacts every part of a person's life, and recovery must do the same. ASAP's Tribal Healing modality recognizes one program cannot "be everything" to "everybody". It must embrace the entire service delivery system and community resources. It discourages "turf protection". The needs of the individual client are identified. Next it is determined what program or person is best able to assist in the identified need area, and referrals or contact is made. The Tribal Healing modality encourages the common good for all, not the best interest of programs or bureaucracy.

The Tribal Healing modality is based on a shared common history. It is a history of survival and endurance. It is a past of which youth can be proud, and lessons they can be taught. The elders are wonderful historians. Their stories, which often have hidden meaning relevant to life today, are invaluable in the learning process. Not only do lessons get taught,

but the relationship between the elders and the youth is strengthened. In addition, the values and rituals of the Tribe are passed on to be shared with future generations.

Over the years, the Tribal Healing modality with its bases in the ASAP philosophy has grown and changed. It is the foundation for ASAP's program planning, development, implementation, and revisions. It is the cornerstone in this pioneering effort to empower the Tribal members to overcome the devastating effects of substance abuse and promote healthy life styles for future generations.

## **CHAPTER IV**

### **SUMMARY**

Substance abuse is more than just a health issue. It is a disease that affects the entire individual's life and those with whom that person comes into contact. Its impact is felt throughout all aspects of one's life and one's environment. The nature of the disease allows its victim to be weak, irresponsible, and unaccountable for actions taken not only while under the influence but after the disease's onset.

One of the identified symptoms associated with the disease is a violation of one's value system. When individuals violate their own values and those accepted by their society, dysfunction is prevalent. With substance abuse at its current level, dysfunction has permeated into all levels of our society which is apparent by the social problems society faces today, such as the high unemployment rates, high school dropout rates, high suicide and teen pregnancy rates among Native peoples.

Substance abuse diminishes the inherent "good" quality within all people and allows for inappropriate behavior. No one starts out wanting to abuse or neglect their children; but in the craziness, they do. No one intends to sexually molest their children; but in the craziness, they do. No one begins life wanting to destroy themselves, others, Mother Earth, the Creator, or mankind; but through their life experiences, they do. No one sets a goal to break the law, but they do. If values are not taught and modeled by those around us, we will follow in their footsteps. The goal of a community-based program must be to "break the cycle" and to hold individuals accountable for their behavior whether they are drunk or sober.



Consequences for inappropriate behavior in accordance to society's values must be set, and then individuals must be held accountable. ASAP's goal is to determine Tribal appropriate tribal behavior based on a culturally-based value system and to design services to empower individuals to overcome dependency on alcohol and other drugs and move towards being healthy contributing members of the Tribes.

Through the years of the Alcohol Program and then ASAP's operation, the most important impact has been the increased level of awareness among the Flathead Reservation residents, both Indian and non-Indian, of the effects of substance abuse on the individual, family, communities, and the Tribes. In a needs assessment recently completed by the Beyond Blue Bay, 85 percent of the respondents view alcohol use in the community as a crisis or serious situation on a five point scale developed by EMT (EMT:10). This is a tremendous change from the time when only the "skid row" drunk was believed to be impacted by alcoholism and drug addiction. Although total responsibility for the increased awareness cannot rest solely with ASAP, it definitely is a contributing factor through its continual and consistent provision of services promoting a theme of a drug-free lifestyle.

The once prevalent attitude which accepted "drunkenness" or drunken behavior as normal or acceptable has been positively impacted. Today an individual's use is questioned, and the enabling behavior is not as wide-spread. For example, all activities sponsored by the Tribe are alcohol free, and an individual's use is a consideration for the election to be a tribal council member.

Tribal programs recognize substance abuse as an issue which must be addressed by many agencies other than just ASAP. For example, Tribal Health Nursing works diligently with

women of childbearing age to inform them on Fetal Alcohol Syndrome (FAS). The Tribal Housing Authority enforces a strict anti-drug policy in their housing units. Both Kicking Horse Job Corp Center and Two Eagle River School have joined with ASAP to work on developing effective early intervention programs for students attending these education institutions. The Tribal Natural Resources Department and the Tribe's utility company, Mission Valley Power, have been the most supportive of employees attending ASAP's training on the chemical dependency and the Drug Free Workplace Act of 1988. They encourage not only personnel at the supervisory level but all their employees to attend. Mr. Joseph Dupuis, the current Tribal Executive Secretary who supervises Tribal Administration and Department Heads, has made a personal commitment to recovery based on his support of the community-based model promoted by ASAP.

The sobriety movement on the reservation has supported the revitalization of the traditional practices of the Tribe's culture. Alcohol and drug use had not role in the traditional activities. These activities were conducted in alcohol and drug free environments. The Tribal Mental Health Program with ASAP actively supports many activities with the Salish Culture Committee. These activities include language camp, gathering roots and medicines, feasts, and opportunities to share traditional crafts such as beading, quillwork, or tanning hides.

## REPLICABILITY TO OTHER PROGRAMS

This community-based approach is applicable to other human services programs. For example, the Tribal Social Services Program (TSS) could possibly have greatest impact from the services provided by ASAP. Furthermore, TSS could be the one agency on the Reservation which will take the lessons learned from developing this community-based service model and apply them to their service delivery system. TSS provides some unique similarities to ASAP. For example, the clients (i.e., children) of TSS are almost exclusively from the same families served by ASAP. One hundred percent of the children placed in foster care through TSS are placed with other families due to their family of origin's alcohol or drug abuse. The vast majority of the referrals to the Child Protection Services (CPS) component for child abuse and neglect are alcohol or drug-related. The majority of recipients receiving General Assistance (GA) subsidy payments are in such a position, at least indirectly, as a result of substance abuse.

Besides similar clientele, TSS is also charged with the responsibility of providing services to a difficult population. The clients place great demands on the services provided while accepting little personal accountability. For many of the clients, the behavior has been learned through multiple generations involved in the Social Services Programs. For example, one case in TSS involves three children being placed in the same foster home the mother was placed in as a child. In both instances, the placement in foster care is the result of the respective mother's alcohol abuse. It appears that foster care is an "appropriate parenting model" for this particular family and many others within the system, just as alcohol and drug abuse is an "appropriate response" for ASAP clients.

A third similarity is the lack of involvement by the Tribe's governing body, in both of these issues. This problem can be attributed to the decision of those involved in the social programs to not actively engage the Council into the Program's activities. This is based on three primary reasons. The first is the result of the "little success" in working with this extremely difficult population. Councils often times want to see concrete evidence of the success of the services provided. This is difficult because no evaluation effort has been conducted by TSS to attribute its efforts toward client behavior change. In addition, all of the services provided by TSS have been focused on crisis management as opposed to prevention or early intervention. Finally, when the client's behavior does change, it is essential that the client take responsibility for the change rather than the Program if true empowerment has occurred. Although this difficulty can be resolved through proper documentation, efforts have not occurred within TSS to allow this to happen.

Another reason it is difficult to involve the Tribal Council into the issues of child abuse/neglect and substance abuse is that the nature of the issues bring a high emotional intensity. The stories of child abuse are difficult to hear without feeling intense rage and then feelings of hopelessness and inadequacy. It is impossible to legislate change in people's behavior. The result has been twofold: (1) service providers do not share the information with the Council since it is not clear as to the expected outcome and (2) the Council ordinarily does not request and become actively involved because they are unaware of what is an appropriate response.

TSS is in a similar position as the Alcohol Program was in 1984 when the Alcohol Program was forced to make major changes. Based on the experience of the Alcohol Program

and now ASAP, TSS has an excellent opportunity to move in a similar direction. This direction would be based on the acceptance of a guiding philosophy which could be easily adapted from ASAP. It needs to expand its services from only focusing on crisis intervention services for high risk parents. This process began with the submission and awarding of an Indian Child Welfare Act grant to the Bureau of Indian Affairs in March of 1992. TSS staff needs to become empowered within themselves to be equal players with the human services delivery system.

The most important program change for TSS is the development of a community awareness model to engage the entire reservation population in an effort to eliminate child abuse. It must become a community effort, for one Program cannot shoulder the responsibility for its elimination anymore than ASAP can bear full responsibility to eliminate substance abuse on the reservation. For it is only when community members say "Enough is enough" will this issue be resolved. TSS can also play a vital role in increasing awareness and developing recommendations to community action.

At a conference in Denver, CO, in March 1992, Marilyn Van Deber Adler, a former Miss America, elegantly told a group of social services providers her story. It included years of sexual, emotional, and physical abuse by her rich father. Her story brought tears to the eyes of many of the people in the room who later were able to share their own stories of abuse and receive support for healing from the group. When asked what advice she would give service providers, Mrs. Van Deber Adler responded by saying there was an army of survivors of abuse waiting to be mobilized and empowered to assist. This is the challenge TSS must accept to fully address this problem with a comprehensive community-based approach.

## RECOMMENDATIONS

1. Develop community-based programs as opposed to programs based on the medical model. The focus of the programs needs to be the community articulating community norms and holding the individual accountable for their own behavior.
2. Work with individuals within the community who are knowledgeable and practice the ways or culture of the Tribes and empower them to assist in designing culturally relevant services.
3. Provide services in a consistent ongoing manner, with a constant "no use" message to break the present accepted norm of "drunkenness."
4. Support sober leadership and educate the leadership whenever possible regarding substance abuse and the community-based model to overcome it. This would include Tribal Councils and also Tribal administration, department heads, and program managers.
5. Educate all agencies and service providers about the effects of substance abuse and help evaluate their programs in terms of their effectiveness in dealing with clients who are substance abusers.
6. Develop community-based program that addresses the complete continuum of care which is prevention, intervention, treatment, and aftercare.
7. Assist in developing effective employee assistance programs.
8. Assist cultural leaders as they revitalize traditional ceremonies, songs, dances, languages, and rituals.
9. Support all elements of the community whether it be churches, schools, or business as they provide "no use" activities. Provide activities when other parts of the community are not.
10. Support Program staff as they move through their own recovery journeys and provide training whenever possible.

## CONCLUSION

Indian people are at a crossroads in the 1990s. It is an exciting time as many changes are occurring throughout "Indian Country." The changes will impact every aspect of the lives

of Indian people as they put an end to the dysfunctional lifestyle brought about by substance abuse. Dr. Barry Willer stated,

"the culture of the Native Americans in this country is in jeopardy. The epidemic use of alcohol and drugs has been described as 'cultural genocide.' There is less passing on of the history and traditions. The youth are resentful of the older generation. Drugs and alcohol pose a major threat to the cultural longevity of Native American Culture" (Willer:13).

He strongly recommends the development of prevention and rehabilitation programs based on the cultures of the Tribes and aimed at the high risk population (Willer:13). He concludes such programs will result in long term benefits.

The Confederated Salish and Kootenai Tribes have pioneered such a model that can be replicated on other reservations throughout the country. Replication is possible if adequate resources are provided, service providers are willing to change the current system, and tribal councils are able to provide the leadership. The one lesson learned by ASAP is that it is not easy, but it is possible if a core group of individuals stay the course and the community is engaged to support the effort.

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**APPENDIX A**  
**CONTINUUM OF CARE CHART**

# Healing Process

Continuum of Care  
Action Plan  
for the  
Tribal Health Dept.

A. At what level can  
we take action?

What can we  
accomplish?

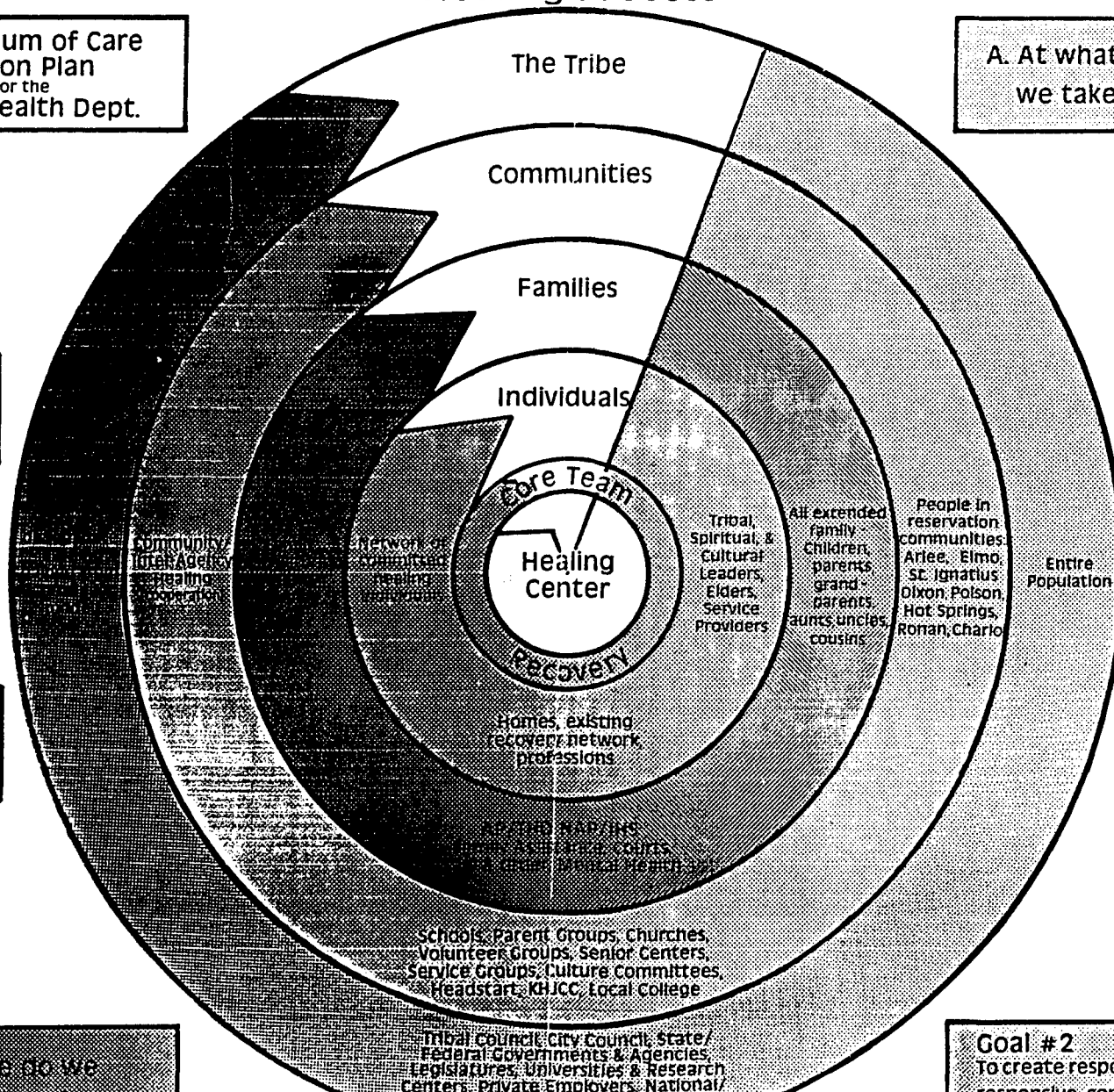
Goal #1  
To foster personal recovery  
for high risk individuals

3  
ene in the generational/  
ycle of substance abuse

B. Whom can we reach

C. Where do we

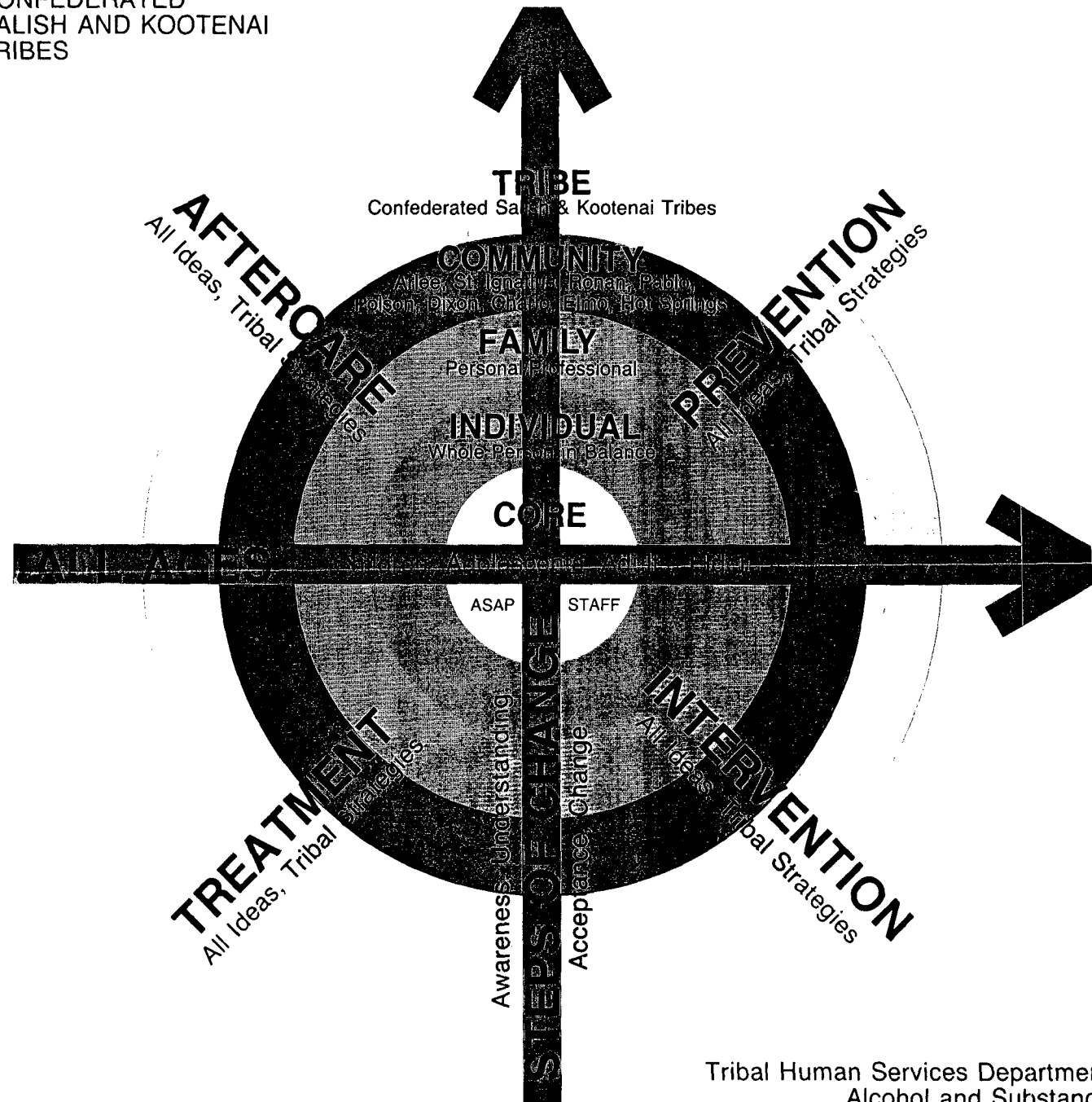
Goal #2  
To create responsible and  
responsive community



**APPENDIX B**

**CONFEDERATED SALISH AND  
KOOTENAI TRIBES CHART**

CONFEDERATED  
SALISH AND KOOTENAI  
TRIBES



Tribal Human Services Department  
Alcohol and Substance  
Abuse Program (ASAP)